



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

**School District Claim for
State Reimbursement for
School Bus Transportation**

State ☐
District ☐
County ☐

**DUE
DATES:**

First Semester
February 1 to County Superintendent
February 15 to State Superintendent

Second Semester
May 10 to County Superintendent
May 24 to State Superintendent

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date		Signature, Chair, Board of Trustees						
County:		District:					District Level:	
36 Phillips		0647 Dodson Elem					Elementary	
Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #
60	2-A	36-2-A-116 North	208	0.95	47	08/03/04	_____	_____
60	2-A	36-2-A-116ANorth	120	0.95	47	08/03/04	_____	_____
60	2-A	36-2-A-116BNorth	88	0.95	47	08/03/04	_____	_____
60	2-A	36-2-A-133 South	133	0.95	48	08/03/04	_____	_____



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

**School District Claim for
State Reimbursement for
School Bus Transportation**

State ☐
District ☐
County ☐

DUE DATES:	First Semester February 1 to County Superintendent February 15 to State Superintendent	Second Semester May 10 to County Superintendent May 24 to State Superintendent
-----------------------	---	---

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date	Signature, Chair, Board of Trustees								
County:	District:						District Level:		
36 Phillips		0648 Dodson H S						High School	
Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #	
40	C	36-2-A-116 North	208	0.95	47	08/03/04	_____	_____	
40	C	36-2-A-116ANorth	120	0.95	47	08/03/04	_____	_____	
40	C	36-2-A-116BNorth	88	0.95	47	08/03/04	_____	_____	
40	C	36-2-A-133 South	133	0.95	48	08/03/04	_____	_____	



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

School District Claim for
State Reimbursement for
School Bus Transportation

State ☐
District ☐
County ☐

DUE DATES:	First Semester	Second Semester
	February 1 to County Superintendent February 15 to State Superintendent	May 10 to County Superintendent May 24 to State Superintendent

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date	Signature, Chair, Board of Trustees
------	-------------------------------------

County:	District:	District Level:
36 Phillips	0657 Saco H S	High School

Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #
25	B	1	130	1.15	52	08/04/04	_____	_____
25	B	2	135	0.95	42	09/02/04	_____	_____
25	B	3	109	0.95	42	08/04/04	_____	_____
25	B	4	96.7	1.15	52	08/04/04	_____	_____



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

**School District Claim for
State Reimbursement for
School Bus Transportation**

State ☐
District ☐
County ☐

**DUE
DATES:**

First Semester
February 1 to County Superintendent
February 15 to State Superintendent

Second Semester
May 10 to County Superintendent
May 24 to State Superintendent

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date		Signature, Chair, Board of Trustees						
County:		District:					District Level:	
36 Phillips		0659 Malta K-12 Schools					High School	
Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #
100	14A	1	76	1.15	53	08/17/04	_____	_____
100	14A	2	76.4	1.80	81	08/16/04	_____	_____
100	14A	3	110	0.95	36	08/11/04	_____	_____
100	14A	3-non	110	0.50	36	08/11/04	_____	_____
100	14A	4	93	0.95	21	08/04/04	_____	_____
100	14A	5	85	1.57	77	08/04/04	_____	_____
100	14A	6	92	1.15	52	07/27/04	_____	_____
100	14A	6-NON	92	0.50	52	07/27/04	_____	_____



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

School District Claim for
State Reimbursement for
School Bus Transportation

State ☐
District ☐
County ☐

DUE DATES:	First Semester	Second Semester
	February 1 to County Superintendent February 15 to State Superintendent	May 10 to County Superintendent May 24 to State Superintendent

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date	Signature, Chair, Board of Trustees							
County:	District:						District Level:	
36 Phillips		0663 Whitewater K-12 Schools					High School	
Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #
100	D	1	162	1.15	54	08/16/04	_____	_____
100	D	2	143	0.95	49	08/04/04	_____	_____
100	D	3	80	1.15	54	08/15/04	_____	_____
100	D	4	158	0.95	48	08/04/04	_____	_____
100	D	5	48	0.95	36	08/04/04	_____	_____
100	D	6	118	0.95	43	08/04/04	_____	_____



Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, MT 59620-2501

**School District Claim for
State Reimbursement for
School Bus Transportation**

State ☐
District ☐
County ☐

DUE DATES:	First Semester	Second Semester
	February 1 to County Superintendent February 15 to State Superintendent	May 10 to County Superintendent May 24 to State Superintendent

COMPLETE THIS CLAIM FOR STATE REIMBURSEMENT FOR SCHOOL BUS TRANSPORTATION:

This claim is for the period beginning _____, 20____ and ending _____, 20____.
month day month day

CERTIFICATION:

The information on this form is complete and accurate to the best of my knowledge.

Date	Signature, Chair, Board of Trustees							
County:	District:					District Level:		
36 Phillips		1203 Saco Elem					Elementary	
Percentage	District #	Route #	Miles Per Day	Rate Per Mile	Capacity	Inspection	Days Operated	Bus Driver's Social Security #
75	12A	1	130	1.15	52	08/04/04	_____	_____
75	12A	2	135	0.95	42	09/02/04	_____	_____
75	12A	3	109	0.95	42	08/04/04	_____	_____
75	12A	4	96.7	1.15	52	08/04/04	_____	_____